PLEASE PRINT CLEARLY

Virginia Department of Medical Assistance Services PHARMACY CLAIM FORM

01 Provider Medicaid ID Number	02 Patient's Last Name	02A Patient's First Name	03 Patient's Medicaid ID Number	04 Sex	05 Birth Date MM DD CCYY

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06 Level of Svc	07 Days Supply	08 Refill	09 DAW	10 Patient Loc	11 Resub.Code	12 Original Reference Number	13 Prescription Number

14 Date Dispensed MM DD CCYY	15 NDC Number	16 Metric Decimal Quantity	17 Unit Dose	18 PAMC

19 Prior Authorization Number	20 Prescriber's Medicaid ID Number	21 Diagnosis	22 Amount Billed	23 OCC	24 Payment by Primary Carrier

Partial Fill Information	25 Disp St	26 Qty. Intended to be Dispensed	27 Intended Days Supply	28 Associated RX#	29 Associated Date Dispensed MM DD CCYY

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30 Comments: _____

31 Provider Name, Address and Telephone Number

This is to certify that the foregoing information is true accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds and that any falsification of claims, statements or documents or concealment of material fact may be prosecuted under applicable Federal or State laws.

Signature of Provider or Representative

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DMAS-173 R 6/03

Date (mm-dd-cc-yy): | | | | | 2 | 0 | | |

Pharmacy Claim Form Instructions

The following instruction provides information on filling out this pharmacy claim form. Please remember that your provider manual will always contain the most current information requirements for each field.

General requirements for submission of paper claim forms submitted for Optical Character Recognition (OCR). This technology minimizes manual intervention required for Medicaid claims processing. The requirements are:

- Use typewritten characters in 10 or 12 pitch, non-compressed in every field possible. Hand writing in any field on the form may delay processing. Do not cross out or write over.
- Dot matrix or laser printer fonts are allowed in letter quality only. Do not mix fonts or use italics/script.
- Use upper case alpha characters, black ink and print within the defined blocks. Do not use red ink.
- Do not use special characters such as; dollar signs; decimals; dashes or other symbols.
- Do not fold claims. Mail claims in large envelopes to prevent folding or creasing the form.

Field #	Narrative Description
1.	Enter your 9-digit Medicaid provider ID number. Do not use zeros with slashes.
2.	Enter the patient's last name.
2a.	Enter the patient's first name.
3.	Enter the 12-digit Medicaid Patient ID number.
4.	Enter the patient's sex. M=Male, F=Female.
5.	Enter the patient's birth date. Use MMDDCCYY format. Zero fill as appropriate (e.g., 06012003).
6.	Enter the level of service code if appropriate. 01 = Patient consultation, 02 = Home delivery, 03 = Emergency, 04 = 24-hour service, 05 = Patient consultation regarding generic product selection, 06 = In-home Service.
7.	Enter the days supply.
8.	If this is an original prescription, enter 00. Refill values are 01 to 99.
9.	Enter the Dispense as Written, (DAW) override code of "1" for prescriptions for which "Brand Necessary" is indicated in accordance with the law and Medicaid policy. The value should be used only when the prescribing physician certifies "Brand Necessary" in his or her own handwriting for a prescribed brand name drug that is generically available.
10.	Enter the patient's location. Valid values are 00 = Not specified, 01 = Home, 02 = Inter-Care, 03 = Nursing Home, 04 = Long Term/Extended Care, 05 = Rest Home, 06 = Boarding Home, 07 = Skilled Care Facility, 08 = Sub Acute Care Facility, 09 = Acute Care Facility, 10 = Outpatient, 11 = Hospice.
11.	The Resubmission Code is only used if an adjustment or void is being requested. Enter the appropriate code if requesting the adjustment or void. Valid values are 1033 = Correcting prescriber ID, 1034 = Correcting metric quantity, 1035 = correcting drug code, 1036 = Allowance for Rx less than pharmacy cost, (wholesale invoice attached), 1053 = Other, 1052 = Void.
12.	The Original Reference Number is only used if an adjustment or void is being requested. Enter the 16 digits of the original claim reference number (ICN) of the claim that is to be adjusted or voided. This field must be filled if a code is in field 11.
13.	Enter the prescription's 7-digit Rx number. If this claim line is for an adjustment or void, the Rx number must be the original Rx number on the claim being adjusted or voided.
14.	Enter the date dispensed in MMDDCCYY format. Zero fill as appropriate (e.g., 10012003).
15.	Enter the 11-digit National Drug Code (NDC). Be certain all NDCs entered are current.
16.	Indicate the metric decimal quantity (e.g., 000002.500) of product using the appropriate unit of measure (each, gram, or milliliter).
17.	Enter the appropriate unit dose code. Valid values are 0 = Not specified, 1 = Not unit dose, 2 = Manufacturer's unit dose, 3 = Pharmacy unit dose, 4 = Unit dose for nursing homes.
18.	Prior Authorization Medical Certification code, (PACC). Valid codes are 0 = Not specified, 1 = Prior Authorization, 2 =Medical certification, 3 = EPSDT, 4 = Exemption from Co-pay, 5 = Exemption from prescription limits, 6 =Family planning indicator, 7 = AFDC, 8 = Payor defined exemption.
19.	Enter the 11-digit prior authorization number.
20.	Enter the prescriber's Medicaid provider ID number. Do not use zeros with slashes.
21.	Enter the ICD-9CM diagnosis code if appropriate. If using a 4 or 5-digit code number, do not enter the decimal point.
22.	Enter the usual and customary charge for the prescription. This field should include the dispensing fee. The last two position of the field is for cents only (e.g., 199|09 for $199.09).
23.	Other Coverage Code, (OCC). Valid values are; 00 = Not specified, 01 = No other coverage, 02 = Other coverage exists-payment collected, 03 = Other coverage exists-claim not covered, 04 = Other coverage exists-payment not collected, 05 = Managed Care plan denial, 06 = Other coverage denied-not participating provider, 07 = Other coverage exists-not in effect on date of service (DOS), 08 = Claim is being billed for copay.
24.	Enter the dollar amount paid by the primary payer if COB applies (e.g., 2199|09 for $2,199.09)
25.	Enter a 'P' for a partial fill or a 'C' for a completion of the partial fill. This field should NOT be filled in when filling the full prescription with the intended quantity.
26.	Enter the metric decimal quantity that would have been dispensed as written. Use with a 'P' or 'C' dispensing status. The quantity positions are the same as field 16 (e.g., 000002.500).
27.	Enter the days supply for the metric decimal quantity that would have been dispensed if the prescription were filled as written.
28.	When submitting the completion 'C' claim, enter in field 28 the prescription number from the initial partial fill claim.
29.	When submitting the completion 'C' claim, enter in field 29 the date dispensed from the initial partial fill claim.
30.	Enter comments, if any (i.e., "Claim #3 used for high cholesterol")
31.	Enter the Pharmacy's name, address, and telephone number.
32.	Note the certification statement on the claim form, then sign and date the claim form.